Conference Proceedings

RAND Technical Expert Panel Medicare Advantage (MA) and Part D Contract Star Ratings, July 22, 2020 Meeting

MEETING SUMMARY

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Published by the RAND Corporation, Santa Monica, Calif.

RAND Technical Expert Panel
Medicare Advantage (MA) and Part D Contract Star Ratings

July 22, 2020

MEETING ATTENDEES

Technical Expert Panel Members

NAME	POSITION
Arlene Ash, Ph.D.	Professor and Division Chief for Biostatistics and Health Services Research in the Department of Quantitative Health Services, University of Massachusetts Medical School
Liza Assatourians, J.D.	Vice President of Federal Programs, America's Health Insurance Plans (AHIP)
Anne Burns, R.Ph.	Vice President, Professional Affairs at the American Pharmacists Association (APhA)
Kim Caldwell, R.Ph., B.S.	Principal, Texas Star Healthcare Consulting
Lindsey Copeland, J.D.	Policy Director, the Medicare Rights Center
Darrell Gaskin, Ph.D.	Professor and Director of the Center for Health Disparities Solutions, Johns Hopkins
Emma Hoo, B.A.	Director, Pacific Business Group on Health
Eve Kerr, MD, M.P.H.	Louis Newburgh Research Professor of Internal Medicine, University of Michigan Medical School, Director of the Ann Arbor VA Center for Clinical Management Research, and Director of the Michigan Program on Value Enhancement
Amy Nguyen Howell, M.D., M.B.A.	Chief Medical Officer, America's Physician Groups (APG)
Deborah Paone, Dr.P.H., M.H.S.A.	Performance Evaluation Lead for Quality Measurement, Social Determinants of Health, and Care Innovation, Special Needs Plans (SNP) Alliance
Ninez Ponce, M.M.P., Ph.D.	Professor, University of California Los Angeles Fielding School of Public Health's Department of Health Policy and Management, Director of the Center for Global and Immigrant Health
Patrick Romano, M.D., M.P.H.	Professor of Medicine and Pediatrics, University of California Davis School of Medicine
Allyson Schwartz, M.S.S.	President and CEO, the Better Medicare Alliance
Jane Sung, J.D.	Senior Strategic Policy Advisor, American Association of Retired Persons
Dolores Yanagihara, M.P.H.	Vice President of Analytics & Performance Information, Integrated Healthcare Association (IHA)

RAND Staff

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MEETING SUMMARY

Welcome and Introductions

- The RAND Corporation meeting facilitator and project director, Cheryl Damberg, began the meeting by welcoming attendees, reviewing housekeeping items, and making membership announcements.
    - Dr. Damberg introduced a new Technical Expert Panel (TEP) member Dr. Darrell Gaskin, who has rich experience in research and health policy. Dr. Gaskin is a health services researcher and health economist at Johns Hopkins Center for Health Disparities Solutions.
    - Dr. Damberg announced that TEP member Dr. Amy Nguyen Howell will be leaving the TEP.
- Dr. Damberg reviewed the meeting agenda and goals. During this meeting, the RAND team indicated it would present an overview on measures included in the Star Ratings program and solicit input on: (1) identifying the most important topics or areas to measure, (2) identifying additional measures or measure types that the Centers for Medicare and Medicaid Services (CMS) should include in the future, and (3) other areas for measurement and approaches for measurement.

Overview of Measures in the Star Ratings Program

- Measures are a central element of the Star Ratings program.
- CMS has received feedback from various stakeholders suggesting that measures included in the Star Ratings program should be re-evaluated.
    - For example, the Medicare Payment Advisory Commission (MedPAC) recommended narrowing the set of measures to focus on clinical outcomes and patient experience.
- As background, RAND researchers reviewed the data sources of measures and the number of measures in each measure domain for the 2021 Star Ratings.
- RAND researchers noted that a measure is removed from the Star Ratings program when measure specifications change or performance on the measure has topped out.
    - When significant changes to measure specifications are made, the measure is moved to the Display Page for two years.
    - Measures might be removed or retired from the Star Ratings when they show little variation across contracts' performance and no longer have utility in distinguishing performance between contracts (i.e., they have low reliability) and have topped out.

Identifying the Most Important Topics or Areas to Measure

- Questions posed to the TEP were as follows:
    - ***For the existing measures, are these the right topics or areas of focus?***
    - ***Should there be a smaller set of measures?***
    - ***What measures or measurement areas should CMS prioritize moving forward?***
- A TEP member commented that measures included in the Star Ratings program are fine for the general Medicare population but do not represent what is most

meaningful for beneficiaries who are served by Special Needs Plans (SNPs). SNPs serve a group of highly diverse, low-income patients, who typically have multiple chronic conditions, including behavioral and mental health needs. This TEP member suggested applying a small set of measures to all contracts in combination with population-specific measures.

- A TEP member noted that CMS has a set of guiding principles that, as a starting point, could be applied when re-evaluating measures. Additionally, the Core Quality Measures Collaborative (CQMC) recommends a core sets of measures by clinical area, taking into account measure burden for providers.
- A TEP member suggested focusing on social determinants of health, medication costs, and more-robust measures of care coordination. The member noted that there is a lot of variability across contracts regarding preferred medications and that this variability affects patients' access to medications and medication affordability.
- A TEP member emphasized the importance of care coordination, transitions of care, and patient-reported outcome (PRO) measures. This TEP member also discouraged the use of disease-specific measures because they apply only to a small subset of patients. Instead, the focus could be on quality of life elements, such as depression.
- Another TEP member supported an increased focus on care coordination and transitions of care. She suggested two measures—*C21 Getting Needed Care* and *C26 Care Coordination*—as examples.
- A TEP member noted that the current Star Ratings measures assess a small window of time. She recommended that RAND engage stakeholders involved in the care transition process to identify new measures.
- Reflecting on comments to add more measures to the Star Ratings program, a TEP member noted that it is easy to add measures but that the goal should be to reduce burden and select a small set of measures that are actionable for contracts. Measures need to be prioritized by importance. Chronic conditions are a top priority. Preventive measures, such as vaccines, are also important.
- A TEP member shared key takeaways from their review of a MedPAC report (June 2020 Report to Congress: Medicare and the Health Care Delivery System) which included support for the reduction of measures included in the Star Ratings program, reducing the use of process measures, and focusing on outcome measures and care coordination. Rightfully so, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures have remained central to the Star Ratings program. However, the TEP member stated that administrative measures might be better handled in administrative channels not in the Star Ratings program; for example, the *Call Center—Foreign Language Interpreter and TTY Availability* measure is more appropriate as a topic for regulation or enforcement. The member said that if a plan is not providing language services, its contract should be revoked because of noncompliance.
- A TEP member suggested retiring the *Plan All-Cause Readmissions* measure because it speaks more to hospital performance than to contract performance.
    - A TEP member disagreed with this comment, noting that transitions of care are recognized as a critical gap in care delivery. This includes follow-up care

after hospital stays. Contracts and providers are increasingly interested in the hand off to the primary care provider, in nurse visits, in support in the home, and in meal delivery and home modifications for those who need it after a hospitalization, all of which have been shown to reduce readmissions.

- A TEP member commented that contracts' ability to measure social risk factors is important because contracts cannot manage what they cannot measure. It is the contract's responsibility to identify where its vulnerable populations are located. Additionally, care coordination and transitions are important. This member also found compelling the argument that the *Plan All-Cause Readmissions* measure is more of a hospital measure than a contract measure.
- A TEP member expressed concern that there are too many measures and stated that CMS should refine the measure set. There is a need to focus on vaccines more broadly, not only the flu vaccine. Other important vaccines to measure include shingles, hepatitis and (one day, potentially) coronavirus disease 2019 (COVID-19).
    - Another TEP member highlighted the importance of retaining the flu vaccine measure in 2021 and 2022 in light of COVID-19.
- A TEP member stressed the importance of focusing on care coordination and the role of family caregivers and their interaction with the health care system.

Identifying Additional Measures or Measure Types that CMS Should Include in the Future

- Next, RAND researchers asked the TEP, ***Are there additional measures, or measure types, that CMS should consider adding to the Star Ratings program?***
- A TEP member suggested adding health equity measures which are under development. Suggestions included measuring performance within at-risk populations or using the *Health Equity Summary* measure developed by CMS. Additionally, medication-adherence measures often capture information about the composition of patients rather than contract performance; therefore, the TEP member said, these measures should be candidates for removal.
    - A RAND team member clarified that the *Health Equity Summary* measure is a summary measure that could be added without requiring more data collection.
- A TEP member suggested adding PRO measures within the context of procedures (e.g., knee replacement, hip replacement). The member also suggested measuring underuse of pain management among patients with cancer.
- A TEP member cautioned that, when measuring procedures and surgeries, it is important to be cognizant of inequity. If measurement is not done right, it can ding contracts that enroll more complex patients.
- A TEP member remarked that depression is a huge issue for patients —not just quality of life for people living in Skilled Nursing Facilities (SNFs) but also for those who live in the community. Coordination across providers and settings is key. A measure that reflects care delivered over time and across settings would be ideal.

Considering Other Areas for Measurement and Approaches to Measurement

- Questions posed to the TEP were as follows:

- ***What PROs are important to measure and align with CMS's goal of shifting to PROs that are less burdensome to capture and report?***
- ***Are there measures that could be constructed from encounter data that Medicare Advantage (MA) plans submit to CMS supplemented with other administrative data sources (e.g., Medicare Provider Analysis and Review hospital inpatient data)?***
- ***Given COVID-19, are there other areas of focus that CMS should measure?***

- A TEP member commented that the health plan CAHPS survey is duplicative with the CG-CAHPS provider survey and needs to be modernized. She recommended closing the period between the eligible touch point and when the survey is sent to the patient, shortening the survey instrument and incorporating additional survey modes in addition to the telephone.
  - A member of the RAND team clarified that the intention of the six-month reference period with the health plan CAHPS survey is to measure access and experience over time to understand a broad set of experiences rather than care related to a specific encounter. The approved survey mode is mail with telephone follow-up with nonrespondents. However, there is work underway to explore other survey modes.
- A TEP member recommended reviewing the June 2020 NQF report on PRO measures and applying the PRO measures framework outlined in the NQF report.
- RAND researchers noted that they are exploring the use of encounter data to construct measures. Thus far, there are concerns about the completeness of encounter data.
  - A TEP member reacted that she cannot believe contracts are not penalized for providing incomplete data.
  - A TEP member commented that it is great CMS is looking at how to collect more complete data. Contracts are concerned about missing data too. She is in support of more electronic data collection that does not require chart review.
- RAND researchers also noted that the CAHPS team is working to measure telehealth.
  - A TEP member commented there is a growing focus on telehealth which is an important aspect of care to measure. Telehealth experiences should be measured through the CAHPS survey. Specifically, did patients have the opportunity to participate in telehealth visits and what was their experience of those visits?
  - One TEP member noted that unfortunately, revenue maximization supersedes convenience for the patients, particularly when it comes to site of care.
- It's important to recognize that COVID-19 has had a meaningful effect on vulnerable populations. Access to long term services and support (LTSS), phones and meals has been interrupted.

Follow-Up Comments from the TEP

- After the meeting, RAND researchers sent an email to all TEP members requesting more detail related to several questions:

- ***It was suggested that population-specific measure(s), particularly relevant to SNPs' patient populations, be included in the Star Ratings program. Are there specific measures that should be considered? What areas should be measured?***
- ***Relatedly, CMS evaluates the performance of Medicare and Medicaid Plans (MMPs) under its Financial Alignment Initiative. MMPs serve the dual population in participating demonstration states. There are MMP performance measures that might be suitable for the SNP patient population. Would any of the MMP measures be good candidates for the SNP patient populations?***
    - A TEP member provided several considerations for measuring performance of SNPs:
        - Measures should be both attributable and actionable.
        - Measures should focus on the interdisciplinary care team and coordination of care across the team.
        - Measures should be adjusted to ensure that they do not promote the use of unnecessary tests.
        - SNPs are required to have a personalized care plan for each beneficiary; therefore, an option for measurement is to evaluate the achievement of the beneficiary's goals in their care plan.
        - Before they are moved from the display page, measures should be tested across a variety of plans in different areas to ensure that they are culturally appropriate and are understandable to those with lower health literacy and multiple conditions.
        - Criteria should be established so that SNPs are not penalized for having a higher volume of beneficiaries who are disabled or frail and have more social risk factors. Often, immediate concerns (e.g., food insecurity) take priority. Therefore, the TEP member suggested implementing the Categorical Adjustment Index with both dually eligible beneficiaries and beneficiaries in SNP contracts.
    - Another TEP member noted that there are four SNP-specific measures in the Star Ratings program. Overall, SNPs find these measures useful, but slight modifications to specifications could strengthen them.
        - The intent of the *Care for Older Adults* measures is for older adults to have a thorough assessment of key health and functional status domains within the measurement year. The TEP member recommended CMS expand the eligibility criteria for what counts as an eligible assessment. For example, an Annual Wellness Visit completed by a physical and occupational therapist, registered nurse, or nurse practitioner should be eligible. By expanding the eligibility criteria, patient abrasion (i.e., response fatigue), could be reduced.
    - Additionally, the TEP member recommended applying additional exclusions to some measures (e.g., *Breast Cancer Screening, Colorectal Cancer Screening, Controlling High Blood Pressure, Diabetes Care—Blood Sugar Control, and Diabetes Care—Eye Exam*) for beneficiaries with advanced illness or shortened life expectancy.
        - An example of an exclusion: Medical complexity **and** frailty, such that the treatment or screen puts the individual at higher risk of

substantial adverse event (e.g., fall with injury) **or** there is medical contraindication for the screen or standard as documented in the chart by the physician who attends to care.

- The TEP member recommended removing two measures from the SNP Star Ratings measure set: *Improving or Maintaining Physical Health* and *Improving or Maintaining Mental Health.* The TEP member shared that their internal analyses have demonstrated that these measures do not represent outcomes of care, have not been adequately validated in special needs and diverse populations, have multiple shortcomings in methods and measure adjustments, and have found their results are not actionable.
- A TEP member suggested that instead of stratifying measures, CMS stratify scores by peer groups (e.g., high, medium, and low dual-eligible peer groups).

- ***TEP members expressed support for including PRO measures but there was no specific recommendations about which PRO measures should be high priority candidates. Do TEP members have recommendations on any existing PRO measures that CMS should consider including? What specific patient outcomes should be measured?***
  - A TEP member expressed support for PRO measures, including asking about satisfaction, and family engagement and family reported experience measures.
  - A TEP member commented that PRO measures should be included in the Star Ratings and can be drawn from measures in the National Committee for Quality Assurance (NCQA) Electronic Clinical Data Systems. Specific measures to consider include:
    - *Depression Screening and Follow-up in Adolescents and Adults*
    - The *Patient Health Questionnaire-9 (PHQ-9)* to monitor depression symptoms for adolescents and adults
    - *Depression Remission or Response for Adolescents and Adults*
    - *Unhealthy Alcohol Use Screening and Follow-up.*
      - The TEP member noted that the three depression measures—*Depression Screening and Follow-up in Adolescents and Adults*, *PHQ-9,* and *Depression Remission or Response for Adolescent and Adults*—build on questions that are part of both the Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcomes Survey (HOS), and inform the measure *Improving or Maintaining Mental Health*.
      - Additionally, the TEP member recommended PRO measures that focus on achievement of beneficiary-designated health goals.
  - A TEP member stressed the importance of clarifying what the PRO measure is and to what or whom the observed result is attributed. Context (i.e., who was the provider, what is the timeframe relevant to the response, what life and other nonmedical events/interventions occurred during that timeframe) is needed to understand the patient's response.

- A TEP member commented that SNP and MMP beneficiaries look very different compared to the general MA population; therefore, targeted testing of PROs is needed before PRO measures are introduced to the Star Ratings program. It is critical to test measures across subpopulation groups with multiple chronic and behavioral health conditions, dually eligible beneficiaries as a proxy for persons with high social determinant of health risk factors, frail and very elderly beneficiaries, ethnically and language diverse groups who are also low income, and non–native-born beneficiaries.
- A TEP member expressed concerns about including PRO measures in the Star Ratings. They provided the two HOS measures included in the Star Ratings as examples: *Improving or Maintaining Physical Health* and *Improving or Maintaining Mental Health*. Concerns include significant variability in contract performance year to year, problems with reliability, performance that is heavily influenced by factors beyond the care received by the beneficiary, and limited evidence of the measures' responsiveness to health care interventions.

- ***A TEP member highlighted the importance of family caregivers. What specifically about family caregivers should be measured? Are there existing measures that CMS could use?***
  - In the SNP and MMP populations, caregivers are very important. Caregivers include family members, friends, and paid personal care assistants.
    - Unfortunately, the Medicare system is not structured to identify and document who caregivers are or to measure the experiences of caregivers. A suggested starting point is to identify the caregiver at the time of enrollment, then annually thereafter.
- ***There was support among panelists to reduce reporting burden and therefore reduce the number of measures included in the Star Ratings program. The RAND team was interested in the TEP's thoughts about which existing measures would be their top candidates for retirement. Which measure(s) do not capture an aspect of care that is high priority or a good marker for quality of care?***
  - A TEP member commented that retirement of measures should be driven by empirical analyses, specifically focusing on (1) whether the measure is "topped out," and (2) whether the measure continues to demonstrate contract-level signal (i.e., true variation at the contract level).
    - Microprocess measures for specific conditions such as Rheumatoid Arthritis and Osteoporosis are problematic and should be considered for retirement.
    - Additionally, process measures that are implemented at the provider level—not the contract level—and that cannot be proven to improve health outcomes should be considered for retirement. Examples include *Adult BMI Assessment*, *Care for Older Adults—Functional Status,* and *Care for Older Adults—Pain Assessment.*
    - Finally, administrative measures (i.e., *Call Center—Foreign Language Interpreter and TTY Availability*) are more appropriate for regulation enforcement than inclusion in the Star Ratings. A contract that does not provide language services should be revoked due to noncompliance.

- Another TEP member suggested that administrative or compliance-related measures (e.g., appeals and complaints) should be removed from the Star Ratings.
- A TEP member made the following measure-specific recommendations:
  - *Getting Needed Care* should be retired or respecified. There is no specificity about which provider visit the question refers to, making the information difficult to act on.
  - *Getting Appointments and Care Quickly* should be retired. Several concerns were raised about relying heavily on the long-term memory of the beneficiary, it is not provider specific, and it does not provide context for a wait longer than 15 minutes. Furthermore, applying this time constraint (i.e., 15 minutes) discourages providers from taking more time if needed with a patient, if it results in a delay for the next patient.
  - *Statin Therapy for Patients with Cardiovascular Disease and Medication Adherence for Cholesterol* captures adherence to a medication; sometimes it is clinically appropriate to stop or make medication adjustments.
  - *Osteoporosis Management in Women who had a Fracture* should be retired or updated to be proactive and focus on treating osteoporosis and preventing fractures.
  - *Complaints about the Health Plan* should be updated to include additional exclusion criteria.
  - *Members Choosing to Leave the Plan* should be updated to consider beneficiaries who move plans but stay within the parent organization.
- A TEP member provided general feedback that measures considered for the Star Ratings should be evidence-based, focused on clinical quality outcomes, and developed by consensus-based organizations (e.g., NCQA). New measures should not be based on administrative data.
  - Additionally, evidence-based clinical outcomes measures should be weighted higher than survey measures.
- A TEP member commented that the inclusion of SES-specific measures might be valuable, but must be evaluated to ensure that the measures illuminate rather than mask racial and other disparities in access to and quality of care.
  - Relatedly, a comprehensive health assessment measure, without attribution to specific care and services, might serve only to increase a contract's risk score and increase compensation. A contract's incentive to complete such an assessment is already high and inclusion in the Star Ratings could further accelerate a trend of increased diagnoses regardless of the need for or provision of services.
- A TEP member recommended updating CAHPS measures. They expressed a concern that many of the CAHPS measures are repetitive with provider surveys and not actionable at the contract level. Additionally, there are

concerns about beneficiary recall bias. Obtaining data directly from contracts via claims or encounter data should be explored.

- The Star Ratings measure set has multiple and somewhat duplicative diabetes measures. However, behavioral and mental health measures are lacking. These conditions are extremely important and prevalent in SNP and MMP populations.
  - The Patient-Reported Outcomes Measurement Information System (PROMIS) PRO measures for depression and anxiety are widely used and have potential for inclusion in the Star Ratings.
- A TEP member commented that the most important measures to retain in the Star Ratings are those that capture service quality (e.g., CAHPS) and those that capture network adequacy or access to care.
  - *Diabetes Care—Blood Sugar Controlled* and *Controlling Blood Pressure* are important intermediate outcomes and can be viewed as proxy measures of access.
  - Process measures, such as vaccines and cancer screening, are measures of broad applicability to the Medicare population. Uptake of these processes can be improved by how contracts design and reward their networks, member communications, etc.